Cervical Cancer Screening Policy Change

Effective June 21, 2016, British Columbia’s updated Cervical Cancer Screening Policy will be in effect. This policy reflects the latest evidence and the province’s commitment to reducing cervical cancer incidence and mortality.

Updated Protocols for Cervical Cancer Screening

Screening aims to identify high-grade pre-cancerous lesions which can be treated to prevent the development of cervical cancer. High grade lesions may be treated with ablative and excisional therapies, including laser ablation, loop electrocautery excision procedure (LEEP) and cold knife conization. Cervical cancer may be treated with surgery (hysterectomy) and/or radiation +/- chemotherapy.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Screening Test</th>
<th>Screening Interval</th>
<th>Balance of Screening Harms and Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 25-69</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
</tr>
<tr>
<td>Never had sexual contact*</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
</tr>
<tr>
<td>Have received the HPV vaccine</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
</tr>
<tr>
<td>In same sex relationship</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
</tr>
<tr>
<td>Transgender with a cervix</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
</tr>
<tr>
<td>After total hysterectomy†</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
</tr>
<tr>
<td>Age &lt; 25</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
</tr>
<tr>
<td>Age &gt; 69‡</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
</tr>
<tr>
<td>Immunocompromised women§</td>
<td>Screen</td>
<td>Cytology</td>
<td>Annual</td>
</tr>
<tr>
<td>History of pre-cancerous lesions or cervical cancer</td>
<td>Screen</td>
<td>Cytology</td>
<td>Annual - until 25 years after diagnosis with at least 5 negative cytology in last 10 years</td>
</tr>
</tbody>
</table>

* Sexual contact includes intercourse as well as digital or oral sexual contact involving the genital area of a partner of either gender.
† Including removal of cervix, with no history of pre-cancerous lesions or cervical cancer.
‡ Provided there are 3 negative tests in preceding 10 years and no high risk criteria.
§ Immunocompromised includes those diagnosed with human immunodeficiency virus (HIV/AIDS), lymphoproliferative disorders, an organ transplant, and those under long-term immunosuppression therapy.
Benefits and Harms of Cervical Cancer Screening

While cervical cancer screening has proven very effective in decreasing the incidence of pre-cancer and cervical cancer, like any screening test, it isn’t perfect. Women should be aware of the benefits and harms of cervical cancer screening and make an informed decision to screen.

Benefits of Screening

• Screening where practiced effectively, has resulted in decreased cervical cancer incidence and mortality in women\(^1\).\(^2\).

• Cervical cancer is one of the most preventable cancers. Cervical cancer begins as an infection of the uterine cervix with high risk human papillomavirus (hr-HPV) that needs to persist for many years. The transition from initial HPV infection to invasive cancer seems to take decades in most cases, with a minimal latency period of approximately 7 years\(^3\).\(^4\).

• Cervical cancer screening saves lives. Most cervical cancer cases occur among women who have not undergone screening or who have had a long interval between Pap tests. In BC, about 58% of the 178 patients diagnosed with invasive cervical cancer in 2014 were five years or more overdue for screening\(^5\). The majority of cases are diagnosed in the 30-39 and 40-49 age groups\(^5\).

• Women between the ages of 25-69 stand to benefit the most from screening.

Harms of Screening

• Most HPV infections and pre-cancerous lesions resolve spontaneously, particularly among younger women who are of childbearing age\(^6\).\(^7\).

• Over-diagnosis and treatment of these transient cervical intraepithelial neoplasia (CIN) is associated with substantial harms, including heightened psychosocial consequences in the women treated\(^8\), increased risk of pre-term and low-birth weight babies (especially for women treated with excisional approaches)\(^9\).\(^10\) and unnecessary utilization of health care resources.

• A 2008 study concluded that in the treatment of CIN, all excisional procedures seem to be associated with adverse obstetric morbidity, but among these, only cold knife conisation is associated with a significantly increased rate of severe outcomes\(^11\).

• Initiating screening in women under 25 can produce more harm than benefit, as cervical cancer is not common in women under age 25.

References


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